NOTICE OF INDEPENDENT REVIEW DECISION

Date: August 4, 2003

RE: MDR Tracking #: M2-03-0980-01
IRO Certificate #: 5242

_____ has been certified by the Texas Department of Insurance (TDI) as an independent review organization (IRO). The Texas Workers' Compensation Commission (TWCC) has assigned the above referenced case to _____ for independent review in accordance with TWCC Rule §133.308 which allows for medical dispute resolution by an IRO.

_____ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. In performing this review, relevant medical records, any documents utilized by the parties referenced above in making the adverse determination and any documentation and written information submitted in support of the appeal was reviewed.

The independent review was performed by an Orthopedic Surgeon reviewer who is board certified in Orthopedic Surgery. The Orthopedic Surgeon reviewer has signed a certification statement stating that no known conflicts of interest exist between him or her and any of the treating physicians or providers or any of the physicians or providers who reviewed the case for a determination prior to the referral to for independent review. In addition, the reviewer has certified that the review was performed without bias for or against any party to this case.

Clinical History

Claimant has symptoms of back pain and right-sided lower extremity radicular symptoms allegedly related to a compensable injury of ___. Diagnoses include lumbar disc herniation, lumbar facet syndrome, and myofascial pain syndrome. MRI report of 8/2/02 indicates posterior-central and right-paracentral broad-based 4-millimeter herniation at L5-S1.

Requested Service(s)

Discography at L3-4, L4-5, and L5-S1.

Decision

I agree with the insurance carrier that the requested intervention is not medically necessary.

Rationale/Basis for Decision

A clinical diagnosis of disc herniation has been made and right-sided lower extremity radicular symptoms are documented. Generally, an electromyogram nerve condition study is performed to confirm the clinical diagnosis of disc herniation and radiculopathy and also to objectively localize the pain generator site. If claimant's radicular symptoms are due to a neurocompressive

lesion, the electromyogram nerve conduction study is the gold standard to diagnose radiculopathy, not a discogram.

YOUR RIGHT TO REQUEST A HEARING

Either party to this medical dispute may disagree with all or part of the decision and has a right to request a hearing.

If disputing a spinal surgery prospective decision a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **10** (ten) days of your receipt of this decision (20 Tex. Admin. Code 142.5(c)).

If disputing other prospective medical necessity (preauthorization) decisions a request for a hearing must be in writing and it must be received by the TWCC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision (28 Tex. Admin. Code 148.3).

This Decision is deemed received by you 5 (five) days after it was mailed (28 Tex. Admin. Code 102.4(h) or 102.5(d)). A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Workers' Compensation Commission, P.O. Box 40669, Austin, Texas, 78704-0012. **A copy of this decision should be attached to the request.**

The party appealing the decision shall deliver a copy of its written request for a hearing to all other parties involved in the dispute (Commission Rule 133.308 (t)(2)).

This decision by the IRO is deemed to be a TWCC decision and order.